VIRGINIA DEPARTMENT OF HEALTH OFFICE OF QUALITY IMPROVEMENT AND HUMAN RESOURCES 1500 EAST MAIN STREET, ROOM 220 RICHMOND, VA 232,19

(804) 371-4065 / FAX (804) 786-5061

EEO COMPLAINT FORM

*Employee Complaint Notice			Type of Discrimination You Claim Occurred	
Delivery Method (check one):		□ Race/Color	□ Age	
•	•	□ Religion	□ Disability	
□ Walk-In	□ Telephone	□ National Origin	☐ Political Affiliation	
	□ Fax	□ Sex	□ Sexual Harassment	
(please print or	r type)			
Complainant:			W. H. W.	
Address:	: Social Security #:		urity #:	
City/State/Zip	Zip: Date of Birth:			
Home Phone	:	Business Telephone:		
Work Locatio	n:			
Department a	and/or person whom you believe	has discriminated:		
Name:	Market Ma	Date Discrimina	tion Occurred:	
Department:				
State why you	u believe you have been discrimir	nated against (use additional sheets if necessar	y):	
What remedy	do you wish to obtain by filing th	nis complaint?		
l affirm the a	bove information is true to the	best of my knowledge, information a	and belief.	
Signature:			Date:	
Date receive	d in OQIHR:			
Date received	J J			

5/97